STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	C 11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS 60971 and #KS 61566.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility recorded a census of 111 residents. The sample included 4 residents. Based on observation, interviews and record review, the facility failed to review and revise the comprehensive care plan for 2 of the 4 residents (#3 related to incontinence and #4 related to transfers, dentures).	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Findings included:

- Resident #3's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 9/4/12 documented the resident with short and long term memory problems and severely impaired decision making skills. The MDS further documented the resident required total dependence of 2 staff with toilet use and frequently incontinent of urine and occasionally incontinent of bowel, with no toileting program. The MDS documented the resident at risk of developing a pressure ulcer.

The Care Area Assessment (CAA) dated 4/2/12 related to urinary incontinence documented the resident was continent, ambulated and toileted self prior to hospitalization for a hip repair. He/She required assistance with all transfers and toileting now. Because of his/her diagnosis of dementia he/she did not remember to ask for assistance and he/she was on a toileting schedule.

The bladder status assessment dated 3/27/12 documented the resident had daily incontinence episodes and not able to participate in a retraining program.

The revised care plan dated 9/11/12 documented the resident had occasional incontinence of urine related to the diagnoses of dementia. The resident did not remember where the bathroom was located. The approaches included to offer to help the resident in the bathroom, to check the resident's skin for any issues, and determine whether the resident needed a change of underwear every shift.

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F 280	Continued From page 2 On 11/14/12 at 2:20 P.M. direct care staff E and direct care staff F assisted the resident back to his/her room per wheelchair. Direct care staff E asked the resident if his/she needed to use the bathroom and the resident said "yes". Direct care staff E and F then assisted the resident into a standing position and pulled down the resident's pants and pull-up. The pants and pull-up were saturated with a strong ammonia scented urine. The resident's wheelchair seat, which contained a pressure alarm, was also saturated with urine. On 11/15/12 at 7:56 A.M. the resident sat on edge of his/her bed, playing with the bed covers. The personal alarm started to sound and the resident placed the alarm under the bed covers. The resident's pants and pull-up were pulled down to the resident's mid thigh. On 11/15/12 at 7:59 A.M. Administrative staff B and direct care staff G washed their hands and applied gloves and assisted the resident into a standing position. The pull-up and pants were wet with urine. Administrative staff B pushed back the incontinent pads on the bed and uncovered a dried area of urine and feces on the resident's sheet. On 11/15/12 at 11:15 A.M. (3 hours and 15 minutes after earlier incontinent episode) direct care staff I and licensed nursing staff D placed gait belt around the resident's waist and assisted the resident into a standing position and then placed the resident in his/her wheelchair. The recliner had a wet area approximately the size of a dinner plate. Direct care staff I pushed the resident's wheelchair to his/her room and then	F 280		

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F 280	Continued From page 3	F 280		

into the bathroom. After the resident sat on the toilet the wet articles were removed and clean pull-up and pants applied. The wheelchair cushion and the pressure pad was wet with urine on it.

On 11/15/12 at 9:46 A.M. administrative staff B revealed the nursing staff should check the resident every 2 hours for incontinency.

On 11/15/12 at 11:45 A.M. direct care staff I revealed staff should check the resident every 2 hours to make sure the resident was dry.

On 11/15/12 at 3:58 P.M. direct care staff J indicated the staff should toilet and/or check the resident every 2 hours.

On 11/15/12 at 4:53 P.M. administrative staff A revealed the staff should check and change incontinent residents at least every 2 hours and staff should include that on the care plan. The staff should update the care plans at least quarterly and with any changes. The last MDS coordinator resigned and reported when he/she left that he/she had not reviewed the care plans for over 6 months.

The 1/10/08 facility policy "Process for Care Plan Development and Communication" documented the resident's care plan shall identify the residents' needs, problems, strengths, risk factors and measurable goals. The care plan will be reviewed with a change of condition and no less than every 90 days.

The facility failed to review and revise resident #3's care plan related to how often this cognitively

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impaired totally dependent incontinent resident should be checked and changed.

- Resident #4's annual Minimum Data Set 3.0 assessment dated 12/15/11 documented the Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The MDS further documented the resident required extensive assistance of 2 staff with transfers, extensive assistance of 1 with bed mobility, dressing, toilet use, personal hygiene, and frequently incontinent of bladder and bowel.

The Care Area Assessment (CAA) dated 12/20/11 documented for activities of daily living (ADLs) revealed the resident required extensive assistance with most ADLs. He/she needed the assistance of 2 staff for transfers, toileting, and ambulation, and one person assisted for dressing, bathing and personal hygiene.

The care plans last reviewed on 3/29/12 documented the resident required assistance with cares. The approaches included to assist with bed mobility and getting in and out of the bed and needed help with transfers as unsteady on his/her feet. Transfers provided by one staff with a gait belt. The resident was very active in dressing but needed the staff to help with guidance and with his/her shoes and socks.

The care plan lacked interventions regarding denture care or use of the pivot disc.

On 11/14/12 at 2:58 P.M. the resident sat in his/her recliner in his/her room watching TV. The resident indicated the staff have to help him/her

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get up and down as he/she was unable to do that anymore. The resident also indicated the staff take care of his/her dentures every night by soaking the dentures. The staff change my brief when I tell them it needs to be changed. The resident indicated that he/she did not use the bathroom anymore.

On 11/15/12 at 2:35 P.M. direct care staff J placed a gait belt around the resident and with the use of a pivot disk (round disc that helped a person turn) stood the resident and sat him/her in the wheelchair and then placed the wheelchair next to the bed. Direct care staff then again used the pivot disc to transfer the resident into his/her bed.

On 11/15/12 at 3:58 P.M. direct care staff J revealed the resident did not use the toilet very often any more. The staff used the pivot disc for all of the resident's transfers. He/she can not stand very good and that helped with the transfers. He/she took his/her dentures out every night and we soak them.

On 11/15/12 at 4:15 P.M. licensed nursing staff M revealed the resident did not do anything for himself/herself anymore. The staff used the pivot disc to help with his/her transfers. He/she was incontinent of bladder and occasionally would ask to use the bathroom for his/her bowels but not very often. The nurse could update the care plans but the nurses usually did that after a fall or when something new came up. The MDS coordinator was the staff who mainly updated and reviewed the care plans.

On 11/15/12 at 4:53 P.M. administrative nursing

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F 280	Continued From page 6 staff A revealed staff should review the care plans at least quarterly and with any changes. The last MDS coordinator resigned and reported when he/she left that he/she had not reviewed the care plans for over 6 months. The 1/10/08 facility policy "Process for Care Plan Development and Communication" documented the resident's care plan shall identify the residents' needs, problems, strengths, risk factors and measurable goals. The care plan would be reviewed with a change of condition and no less than every 90 days. The facility failed to review and revise resident #4's care plan related to transfers and denture care for this dependent resident.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility recorded a census of 111 residents. The sample included 4 residents. Based on observation, interviews and record review, the facility failed to provide complete and timely	F 315		

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incontinent care for 1 out of 2 residents documented with incontinency (#3).

Findings included:

- Resident #3 quarterly Minimum Data Set 3.0 Assessment (MDS) dated 9/4/12 documented the resident with short and long term memory problems and severely impaired decision making skills. The MDS further documented the resident required total dependence of 2 staff with toilet use and frequently incontinent of urine and occasionally incontinent of bowel, with no toileting program. The MDS documented the resident at risk of developing a pressure ulcer.

The Care Area Assessment (CAA) dated 4/2/12 related to urinary incontinence documented the resident was continent, ambulated and toileted self prior to hospitalization for a hip repair. He/She required assistance with all transfers and toileting now. Because of his/her diagnosis of dementia he/she did not remember to ask for assistance and he/she was on a toileting schedule.

The bladder status assessment dated 3/27/12 documented the resident had daily incontinence episodes and not able to participate in a retraining program.

The revised care plan dated 9/11/12 documented the resident had occasional incontinence of urine related to the diagnoses of dementia. The resident did not remember where the bathroom was located. The approaches included to offer to help the resident in the bathroom, to check the resident's skin for any issues, and determine

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whether the resident needed a change of underwear every shift.

On 11/14/12 at 2:20 P.M. direct care staff E assisted the resident to his/her room per wheelchair. Direct care staff E asked the resident if his/she needed to use the bathroom and the resident said "yes". Direct care staff E and F assisted the resident into a standing position and pulled down the resident's pants and pull-up. The pants and pull-up were saturated with a strong ammonia scented urine. The resident's wheelchair seat, which contained a pressure alarm, was also saturated with urine. Direct care staff E and F then sat the resident on the toilet. Direct care staff F removed the saturated pants and pull-up and placed them in a plastic bag. Direct care staff F removed his/her gloves and washed his/her hands and applied new gloves. Direct care staff E assisted the resident with putting on a new pull-up and pants. Direct care staff F asked the resident is he/she was done and the resident stated yes. Direct care staff E and F had the resident hold onto the grab bar, stand up, and used 4 wet wipes to cleanse the rectal area and then 1 wet wipe to cleanse the front of the perineal area. Direct care staff E then pulled up the resident's pull-up and pants and assisted the resident to sit down onto the unclean wheelchair. Direct care staff F pushed the resident in his/her wheelchair to the activity room.

On 11/15/12 at 7:56 A.M. the resident sat on the edge of his/her bed and played with the bed covers. The personal alarm started to sound and the resident placed the alarm under the bed covers. The resident's pants and pull-up were down to the resident's mid thigh.

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F 315	Continued From page 9 On 11/15/12 at 7:59 A.M. administrative nursing staff B and direct care staff G went into the resident's room. Administrative staff B revealed that the resident had been combative this morning when the staff had tried to get him/her out of bed, so the staff left him/her and were going to return to try again. Administrative staff B and direct care staff G washed their hands and applied gloves and assisted the resident into a standing position and staff noted the pull-up and pants wet with urine. Administrative staff B pushed back the incontinent pads on the bed and uncovered a dried area of urine and feces on the resident's sheet. Administrative staff B and direct care staff G sat the resident back down on the side of the bed. Direct care staff G then left the resident's room to gather supplies to clean the resident with. On 11/15/12 at 8:14 A.M. licensed nursing staff C entered the resident's room to assist the resident. Licensed nursing staff C informed the resident of everything that he/she was doing and the resident started to get agitated with the staff. Licensed nursing staff used 2 wet wipes to cleanse the front perineal area and then had the resident stand with assist of administrative staff B and direct care staff G, and provided incontinent care to the rectal area with 2 wet wipes to cleanse the center of the coccyx. Direct care staff G pulled up the resident's pull-up and pants and sat the resident in the wheelchair. The staff did not cleanse all areas that came in contact with the urine. On 11/15/12 at 9:10 A.M. the resident finished breakfast and went to the living room.	F 315		

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On 11/15/12 at 9:38 A.M. direct care staff H observed the resident leaning to his/her left side and appeared to be sleepy. Direct care staff H removed the resident from the activity area and pushed his/her wheelchair to the TV area and with the assistance of direct care staff G, placed the resident in a recliner. The resident slept in the recliner facing the TV until 10:56 A.M.

On 11/15/12 at 10:56 A.M. the resident was awake and played with his/her personal alarm and kicked his/her legs off the recliner.

On 11/15/12 at 11:14 A.M. direct care staff H replaced the resident's legs on the recliner.

On 11/15/12 at 11:15 A.M. (3 hours and 15 minutes after earlier incontinent episode) direct care staff I and licensed nursing staff D placed gait belt around the resident's waist and assisted the resident into a standing position and then placed the resident in his/her wheelchair. The recliner had a wet area approximately the size of a dinner plate. Direct care staff I pushed the resident's wheelchair to his/her room and then into the bathroom. Licensed nursing staff D and direct care staff I assisted the resident into a standing position. Licensed nursing staff D encouraged the resident to hold onto the grab bar while pulling down his/her pants and pull-up, then pivoted the resident onto the toilet. After the resident sat on the toilet the wet articles were removed and a clean pull-up and pants applied. The wheelchair cushion was wet with urine and the pressure pad also noted with wet urine on it. Licensed nursing staff D used 2 wet wipes to clean the coccyx area. The resident said "ouch"

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with both swipes. Licensed nursing staff D observed the coccyx area and noted the red area. Licensed nursing staff D applied a barrier cream to the coccyx area. Direct care staff I pulled up the resident's clothing. Licensed nursing staff D and direct care staff I sat the resident on the urine covered cushion in the wheelchair. The staff did not cleanse all areas that came in contact with the urine.

On 11/15/12 at 9:46 A.M. administrative staff B revealed the nursing staff should check the resident every 2 hours for incontinency. The housekeeping staff would clean the recliner with a special machine.

On 11/15/12 at 11:45 A.M. direct care staff I revealed the staff should check the resident every 2 hours to make sure the resident are dry.

On 11/15/12 at 3:58 P.M. direct care staff J indicated staff should toilet and/or check the resident every 2 hours.

On 11/15/12 at 4:53 P.M. administrative staff A revealed the staff should check and change incontinent residents at least every 2 hours. The staff should use barrier cream for residents that were incontinent to protect their shin. All devices that had urine on them should be cleaned prior to usage.

The revised 3/5/08 facility policy "Routine Perineal Care" documented that perineal care is provided to promote cleanliness, prevent infection and remove irritating and odorous secretions.

The facility failed to provide complete and timely

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F 315	Continued From page 12 incontinent care for this cognitively impaired dependent resident and failed to cleanse the assistive devices with urine on them.	F 315		